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Biofilm formation is a risk factor for mortality in patients with *Candida albicans* bloodstream infection—Scotland, 2012–2013

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# **Palliative Care Congress abstracts**

**The 11<sup>th</sup> Palliative Care Congress  
9<sup>th</sup> – 11<sup>th</sup> March 2016**

**The Scottish Exhibition and Conference Centre (SECC)  
Glasgow, Scotland, UK**

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	Initial audit (%)	Re-audit with sticker (%)
Date	20 (100%)	22 (100%)
Time	19 (95%)	22 (100%)
Consultant/ lead SpR name	16 (80%)	22 (100%)
Names of other medics present	20 (100%)	20 (91%)
Name of Nurse	20 (100%)	15 (68%)
Names of family/ carers	8 (40%)	4 (18%)
Expectations reviewed	3 (15%)	20 (91%)
Meds reviewed	13 (65%)	21 (95%)
Pain chart reviewed	7 (35%)	20 (91%)
Obs chart reviewed	7 (35%)	19 (86%)
Stool chart	6 (30%)	20 (91%)
Plan established	18 (90%)	22 (100%)

subsequently adopted for all patients and re-audit of 22 entries over a two week period completed two months later.

**Results:** The initial audit demonstrated whilst basic demographics were well recorded in records, that few families were present for reviews, and patients' expectations infrequently recorded. Re-audit showed significant improvements in reviewing patients' expectations and symptom charts; however a disappointing lack of families and falling numbers of nurses attending the round.

**Conclusions:** The team round ensures a decision making meeting happens weekly between healthcare professionals and patients. The sticker has been well received by staff and acts as a useful visual reminder of key points to include at this review.

Ongoing education of staff is needed to ensure team round attendance, including during periods of short staffing. Posters advertising "team round times" have subsequently been displayed at Hayward House to encourage families and carers to attend, and we will repeat this audit to review their impact.

#### Poster No. 203

##### Palliative Care Physiotherapy Quality Improvement Project and Vision

*Sonia Connors<sup>1</sup>, Laura Calvert<sup>1</sup>, Sarah Gray<sup>1</sup>, Louise Lewis<sup>1</sup>, Emma Secker<sup>1</sup>, Diane Stout<sup>1</sup>*

<sup>1</sup>Northumbria Healthcare NHS Foundation Trust, North Shields, England

**Background:** Palliative care Physiotherapy aims to improve patient quality of life, regardless of prognosis by helping achieve maximum potential of functional ability and independence, or gain relief from distressing symptoms (ACPOPC 1993). Within Northumbria Healthcare

Trust, Palliative Care Physiotherapy services consisted of lone workers within multiple providers, across a large geographical area, with limited cross boundary co-operation. With the acquisition of 2 community trusts by Northumbria, community and hospital services came together to offer palliative care services to a population of around 500,000.

This provided the opportunity for a Quality Improvement Project, to develop an all-encompassing high quality Palliative Care Physiotherapy service, which could provide an equitable service across community and inpatients.

**Process:** A retrospective collection of data was undertaken to demonstrate differences between providers. Data included number of referrals over a one year period, source of referrals, length of time from referral to contact and the reasons for this.

An interactive development session identified different models of working that may prevent a cohesive service. An action plan was created to take the project forwards.

**Outcome:** A rota for service cover is in development. Skills matrix identifying education needs completed. A Daily Huddle in one area enhancing multi-professional communication. A regular Peer Support group. On-going outcomes include; development of referral criteria, a prioritisation statement, agreed response times, and monitoring of capacity and demand as parts of the trust are rural and less densely populated than others.

**Challenges:** management changes, changing staffing levels, agreement of standards. Evaluation data will be collated and presented at conference.

**Conclusion:** In conducting this project, the team expects to be able to work towards a high quality cohesive service, providing high quality Palliative Care Physiotherapy.

#### Poster No. 204

##### Introducing validated outcome measures into a Scottish Hospice

*Caroline Sime<sup>2</sup>, Sandra McConnell<sup>1</sup>, Carol Pyper<sup>1</sup>, Ros Park<sup>1</sup>, Paul Bett<sup>1</sup>, Stuart Milligan<sup>1</sup>, Anne Mills<sup>2</sup>, Kevin Rooney*

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**Background:** Quality healthcare aspires to be person-centred, safe and effective (Scottish Government, 2010). Within the specialist palliative care setting, the use of patient reported outcome measurement is one way of promoting a person-centred approach to care, and improving the quality of services provided. To date however, the use of validated outcome measures in clinical practice is still in its infancy, despite evidence to suggest its effectiveness at improving patient outcomes (Bausewein et al, 2015, Clark, 2015).

**Aims:** At Ardgowan Hospice we aimed to introduce two measures: Phase of Illness and the Integrated Palliative

Outcome Scale (IPOS) into all clinical areas. This was a two phased study. The first phase focused on the successful introduction of Phase of Illness and IPOS into the inpatient unit (IPU) and the community specialist nursing (CNS) team. The second phase was rolling out the implementation to day services and outpatient clinics.

**Methods:** Using quality improvement tools, we carried out Plan, Do, Study, Act (PDSA) test cycles of change. Change ideas tested included different methods to engage staff including staff seminars and training, IT software development, and patient involvement and feedback. The PDSA test cycles were reflected upon and the lessons learned used to inform new test cycles.

**Results:** Multiple test cycles were undertaken within clinical areas. Reflective learning from each test cycle found the most important contributors to a successful test were:

- Consistent and timely staff training
- Facilitation of measures driven by clinical leads
- Sharing of information to inform person-centred care
- Ease of completion for staff and patients.

**Conclusions:** The adoption of an improvement approach has facilitated a phased and systematic implementation of outcome measures at Ardgowan Hospice. Using these outcome measures has enhanced person-centred care, by focusing on what matters to the patient, and is informing the weekly multidisciplinary meetings which coordinate ongoing care.

#### Poster No. 205

##### **An Audit of Quality of Clerking Documentation at St Richard's Hospice, Worcester**

*Katherine Armstrong<sup>1</sup>, Nicola Wilderspin<sup>1</sup>*

<sup>1</sup>St Richard's Hospice, Birmingham, England

**Background:** Maintaining good quality documentation of hospice admission clerking is vital to meet the varied psychological, social and physical needs of palliative patients. Unfortunately, there are no existing national or local guidelines which address this and therefore standardised patient care may be compromised.

**Aims:** We aimed to evaluate the quality of clerking at St Richard's Hospice in terms of addressing patient needs.

73 patient admissions from November 2014-January 2015 were reviewed using electronic patient records. We assessed two aspects of documentation for each admission - patient safety and quality of care, and chose areas within these pertinent to palliative care. For patient safety, we noted whether VTE assessment and DNACPR status had been documented. Standards were set at 100%. For quality of care, we assessed documentation of spiritual assessment, setting standards at

80% acknowledging this is an ongoing assessment undertaken by the MDT. Furthermore, we looked at information required after death noting documentation of presence of pacemaker, surgical history and occupation. Standards for this were set at 70%, reflecting that not all patients admitted to the hospice were for end of life care.

**Results:** VTE assessment was documented in 71%, and DNACPR status in 89%. Any aspect of spiritual assessment was documented in 59%. Pacemaker status was documented in 77%, occupation in 71% and surgical history in 63%.

**Conclusion:** There were widespread shortcomings in clerking documentation. If decisions regarding VTE prophylaxis or DNACPR are omitted, this will affect patient safety. Psychosocial care of patients is neglected by not addressing spiritual needs or having to contact the family to acquire information necessary for after death for cremation forms.

We suggest a clerking pro-forma as well as changes to the electronic system in order to improve care of palliative patients and a re-audit is underway.

#### Poster No. 206

##### **Use of the Distress thermometer as an Outcome measure in a Hospice Inpatient Setting**

*Sarika Hanchanale<sup>1</sup>, Lucie Shipley<sup>1</sup>, Lynne Russon<sup>1</sup>*

<sup>1</sup>Sue Ryder, Wheatfields Hospice, Leeds, UK

**Background:** Outcome measures (OM) are becoming an important part of measuring the quality of a services for commissioning. European Association of Palliative Care recommends that palliative care teams should use outcome measures in order to improve quality of services.

**Objectives:** We trialled the use of distress thermometer (DT) as an introduction for staff and patients of measuring outcomes and improvements in symptoms, to assess quality of care and our ability at addressing patients' needs.

**Method:** Twenty three patients were admitted in November 2014. We asked all admissions during the month to complete DT.

DT tool: This consisted of a list of symptoms which are divided into physical, social, psychological and spiritual domains. Alongside a thermometer (scale 0-10), patients were asked to score the top three symptoms which caused the most distress. The scores were completed on admission and then one week later.

**Results:** 52% of the patients were unable to complete the form for reasons including confusion, dying, aphasic, frail, and fatigued. Only one patient declined to participate. One commented that the scale was difficult to understand. 35% completed the form in the first week. In 9%, data wasn't collected. Pain was the most common symptom and improved in all patients. We were able to